

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=62-015597**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration Division No. **146**

Primary Registration District No. **3026**

Registrar's No. **179**

**FILED APR 17 1962**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		c. CITY OR TOWN <b>Independence</b>	
Length of stay in 1b <b>16 yrs</b>		Inside Limits <b>Yes</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Independence Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>702 28th North</b>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leona M. McDaniel</b>		4. DATE OF DEATH Month Day Year <b>APRIL 8 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-1922</b>
9. AGE (last birthday) <b>40</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (City and state or country) <b>Pender, Nebr.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Melvin E. Leonard</b>		13b. MOTHER'S MAIDEN NAME <b>Elsie Lueders</b>	
14. NAME OF HUSBAND OR WIFE <b>J. Frank McDaniel</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT <b>J. Frank McDaniel, 702 28th North</b>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Lupus Erythematosus - 10 yrs.</b>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>3/29/62</b> to <b>death 4/8/62</b> and last saw her <b>alive on</b> <b>7:17 a.m. 4/8/62</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Alba L. Craig M.D.</b>	
22b. ADDRESS <b>10901 Winner Road, Independence, Mo.</b>		22c. DATE SIGNED <b>4/9/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-10-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills, Inc</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>Blue Ridge &amp; Gregory</b>		25. DATE RECD. BY LOCAL REG. <b>4-10-62</b>	
26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. M. Jones

Licensed Embalmer No. 3463

P. O. Address H. C. Han

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

APR 17 1962

10901 E. 1st Ave  
St. Paul, Minn. 55104  
Phone 10-6000

4-10-62